such time as the additional net patient service revenue becomes part of base year net patient service revenue. Thereafter, unadjusted net patient service revenue shall be used for the purposes of regional disproportionate share pool distributions in accordance with subdivision (k) of this section.

(4) Nominal payment amount shall be defined as the sum of the dollars attributable to the application of an incrementally increasing proportion of reimbursement for percentage increases in targeted need according to the scale specified in subparagraphs (iii) and (iv) of subdivision (d)(2) of this section.

(5) For rate periods prior to January 1, 1997, targeted need share shall be defined as the ratio of each hospital's nominal payment amount to the nominal payment amounts for all hospitals in the region other than major public general hospitals. For rate periods commencing January 1, 1997 and thereafter, targeted need share shall mean the relationship of each general hospital's nominal payment amount of uncompensated care need determined in accordance with the scale specified in subparagraph (iv) of subdivision (d)(2) of this section to the nominal payment amounts of uncompensated care need for all eligible general hospitals applied to funds available for distribution pursuant to this section.

5' Major public [~~sector~~] general hospitals shall mean all State-operated general hospitals, all general hospitals operated by the New York City Health and Hospitals Corporation as established by chapter 1016 of the Laws of 1969, as amended, and all other public general hospitals having annual inpatient operating costs in excess of $25 million.

(7) Voluntary sector hospitals shall mean all voluntary nonprofit, private proprietary and public general hospitals other than major public general hospitals.

(8) Financially distressed hospitals shall mean those hospitals that meet the criteria specified in section 86-1.66 of this Subpart.

(9) For rate periods prior to January 1, 1997 statewide resources shall mean the sum of the result of multiplying a statewide average 5.48 percent by each general hospital's (including major public hospitals and all other hospitals) rate year reimbursable inpatient costs used in the initial promulgation of rates, adjusted of case mix and volume changes, excluding inpatient costs related to services provided to beneficiaries of title XVIII of the federal Social Security Act (Medicare), and without consideration of inpatient uncollectible amounts, and including income from invested funds. When a prospective adjustment is made to a rate of payment to reflect the retroactive impact of an adjustment in accordance with section 86-1.61(l), no recalculation of disproportionate share payments described in this section shall be made to reflect this prospective adjustment for the prior rate year.

(10) For rate periods prior to January 1, 1997, financially distressed resources shall mean the sum of the result of multiplying .325 percent by each general hospital's (including major public hospitals and all other hospitals) rate year reimbursable inpatient costs used in the initial promulgation of rates, adjusted for case mix and volume changes, excluding inpatient costs related to services provided to beneficiaries of Title XVIII of the federal Social Security Act (Medicare), and without

consideration of inpatient uncollectible amounts, and including income from invested funds.

(11) The regions are established as the article 43 insurance plan regions, with the exceptions that the southern 16 counties shall be divided into three regions with separate regions consisting of Richmond, Manhattan, Bronx, Queens and Kings Counties; Nassau and Suffolk Counties; and Delaware, Columbia, Ulster, Sullivan, Orange, Dutchess, Putnam, Rockland and Westchester Counties. Such regions shall be the same regions established and in effect January 1, 1985. The council with the approval of the commissioner may combine regions, with the exception of the specified regional for the southern 16 counties, upon application of the article 43 Insurance Law plans involved and a demonstration that significant inequities would not occur. Hospitals not participating as of December 31, 1985 in the regional bad debt and charity care pools established pursuant to section 86-1.11(q) and (p) of this Subpart and no longer exempt from the provisions of this Subpart for reimbursement purposes shall be assigned to a region for purposes of determining the disproportionate share payments pursuant to this section. Assignment to a region shall be based upon but not limited to the following factor:

(i) numbers and types of hospitals within the regions; and
(ii) geographical proximity of the hospital requiring such assignment to a particular region.

(12) For rate periods commencing January 1, 1997 and thereafter, uninsured care shall be defined as losses from bad debts reduced to cost and the costs of charity care of a general hospital for inpatient and ambulatory services, excluding referred ambulatory services, which are not eligible for payment in whole or in part by a governmental agency, insurer or other third-party payor on behalf of a patient, including payments made directly to the general hospital and indemnity or similar payments made to the person who is a payor of hospital services. The costs of services denied reimbursement, other than emergency room services, for lack of medical necessity or lack of compliance with prior authorization requirements, or provided as an employment benefit, or as a courtesy shall not be included.

(13) In order to be eligible for distributions, a general hospital's targeted need must exceed one-half of one percent.

c. In order for a general hospital to qualify for Medicaid disproportionate share payments, the general hospital must adhere to the following policies:

(1) To be eligible to receive payments, a facility must meet the criteria specified in section 86-1.11(q)(1) of this Subpart with the following exception. A policy which is consistent and follows commonly accepted business methods and practices concerning the time period that must elapse between initial billing and the determination that an unpaid bill is a bad debt must

(1) For rate years commencing January 1, 1991 and [~~thereafter~~] prior to January 1, 1997, each eligible major public general hospital shall receive a portion of its bad debt and charity care need equal to 110 percent of the result of the application of the percentage of statewide inpatient reimbursable costs excluding costs related to services provided to beneficiaries of Medicare, developed on the basis of 1985 financial and statistical reports, to the statewide resources for the rate year. For rate periods commencing January 1, 1997 and thereafter, each eligible major public general hospital shall receive an amount equal to the amount allocated to such major public hospital for the period January 1, 1996 through December 31, 1996.

(2) For rate periods prior to January 1, 1997, the balance of the statewide resources after the Medicaid disproportionate share payments are made in accordance with paragraph (1) of this subdivision shall be distributed to voluntary sector hospitals on the basis of each hospital's targeted need share. For rate periods commencing January 1, 1997 and thereafter, the balance of unallocated funds after the Medicaid disproportionate share payments are made in accordance with paragraph (1) of this subdivision and funds are reserved for distribution as high need adjustments in accordance with subdivision (h) of this section and shall be distributed to eligible hospitals, excluding major public general hospitals, on the basis of targeted need share adjusted for transition factors pursuant to subdivision (i) of this section.

(i) Need calculations shall be based on need data for the year 2 years prior to the rate year.

(ii) For the rate periods commencing January 1, 1991 and prior to January 1, 1997 [~~thereafter~~], the scale specified in subparagraph (iii) of this paragraph and for rate periods commencing January 1, 1997 and thereafter, the scale specified in subparagraph (iv) shall be utilized to calculate individual hospital's nominal payment amounts on the basis of the percentage relationship between their need for the year 2 years prior to the rate year and their patient service revenues for the year 2 years prior to the rate year.

(iii) The scale utilized for development of each hospital's nominal payment amount shall be as follows:

Targeted Need Percentage	Percentage of Reimbursement Attributable to the Portion of Targeted Need
0 -1 %	35%
1+ -2 %	50%
2+ -3 %	65%
3+ -4 %	85%
4+ -5 %	90%
5+	95%

(iv) The scale utilized for development of each eligible general hospital's nominal payment amount shall be as follows:

Targeted Need Percentage	Percentage of Reimbursement Attributable to the Portion of Targeted Need
0 -0.5 %	60%
0.5+-2 %	65%
2+ -3 %	70%
3+ -4 %	75%
4+ -5 %	80%
5+ -6 %	85%
6+ -7 %	90%
7+ -8 %	95%
8+	100%

(3) For rate periods prior to January 1, 1997, payments may be adjusted based upon certified corrections of data submitted by hospitals and to reflect maintenance of effort between the voluntary and the major public hospital sectors.

(i) Maintenance of effort. The allocation of resources made available pursuant to paragraphs (1) and (2) may be changed only for rate periods ending on or before December 31, 1993 and only after an annual review which shall be conducted by the commissioner with respect to general hospitals' bad debt and charity care need as defined in subdivision (b) of this section within each article 43 insurance law or a combined region. For purposes of this review, rate year 1988, 1989, 1990, 1991, 1992 and 1993 need shall be compared to actual rate year 1986, 1987, 1988, 1989, 1990 and 1991 need, respectively. If as a result of the review, there is a finding that there has been a change within the region of at least five percent in the proportional amounts of bad debt and charity care provided by (1) major public general hospitals, and (2) voluntary nonprofit, private proprietary and public general hospitals, other than major public general hospitals, the allocation of resources between these sectors shall be adjusted to

reflect this change. The percentage decrease if any, in such care provided by the voluntary sector hospitals, in excess of five percent shall be applied to reduce each of the voluntary hospital's bad debt and charity care pool distributions. Likewise, if there is a proportional decrease in the amount of such care provided by the major public sector hospitals, the percentage decrease if any, in excess of five percent shall be measured by subtracting the proportion of total regional need met by a sector in the base year from that sector's proportion in the rate year.

4) Financially Distressed Hospitals

(i) Medicaid disproportionate share payments shall be made to financially distressed hospitals to assist in financing losses resulting from bad debts and the costs of charity care for rate periods prior to January 1, 1997. Payments shall be determined after consideration of payments made in accordance with paragraphs (1) and (2) of this subdivision and shall result in up to 100 percent of the hospital's need being financed. For purposes of payments to eligible hospitals, rate year need shall be based on current rate year need data. Such hospitals must request this additional distribution in writing. For each rate year and prior to payment of these funds, financially distressed hospitals shall uniformly account for and report on services provided to patients for which full payment was not received pursuant to a plan for such uniform accounting and reporting submitted by the hospitals and approved by the commissioner of health.

(ii) Those hospitals that qualified as financially distressed in a rate year but no longer qualify for such status subsequent to the rate year shall receive payments as follows:

(a) two-thirds of the anticipated payment which the hospital would have received had it continued to qualify as financially distressed, shall be paid in the first year in which the hospital does not qualify as financially distressed;

(b) one-third of such anticipated payment shall be paid in the second year the hospital does not qualify as financially distressed; and

(c) no additional distributions shall be available during or after the third year the hospital does not qualify as financially distressed.

the revenue associated with referred ambulatory patients. The charges shall be collected for the entire year, reduced to cost, and compared to the amount of bad debt and charity care distributions received by the hospital for such services. This data shall be collected on forms and in a manner prescribed by the commissioner of health.

(h) For rate periods commencing January 1, 1997 and thereafter, $36 million shall be distributed as high need adjustments to general hospitals, excluding major public general hospitals, with nominal payment amount in excess of 4 percent of reported costs as follows: each general hospital's share shall be based on such hospital's aggregate share of nominal payment amount above 4 percent of reported costs compared to the total aggregate nominal payment amount above 4 percent of reported costs of all eligible hospitals.

(i) For rate periods commencing January 1, 1997 and thereafter, distributions to general hospitals described in subdivisions (d)(2) and (h) of this section shall be adjusted as follows:

(1) For general hospitals which qualified for distributions pursuant to section 86-1.66 of this Subpart as of December 31, 1995:

(i) For the rate period commencing January 1, 1997 and ending December 31, 1997, each such general hospital shall receive as an allocation 100 percent of the projected distribution to such general hospital pursuant to paragraph (4) of subdivision (d) of this section for 1996.

(ii) For the rate period commencing January 1, 1998 and ending December 31, 1998, each such general hospital shall receive as an allocation 75 percent of the amount determined in accordance with subparagraph (i) of this paragraph and 25 percent of the amount determined in accordance with subdivision (h) of this section.

(iii) For the rate period commencing January 1, 1999 and ending December 31, 1999, each such general hospital shall receive as an allocation 50 percent of the amount determined in accordance with subparagraph (i) of this paragraph and 50 percent of the amount determined in accordance with subdivision (h) of this section.

JUN 06 2001
TN 97-06 Approval Date
Supersedes TN New Effective Date JAN 01 1997

(2) For all other general hospitals, excluding major public general hospitals, general hospitals qualifying for an adjustment pursuant to paragraph (1) of this subdivision, general hospitals which qualified for an adjustment pursuant to section 86-1.84 of this Subpart and rural general hospitals that met the qualifications as a rural general hospital pursuant to clause (e) of section 86-1.52 (a)(1)(iv) of this Subpart in 1996:

(i) For the rate period commencing January 1, 1997 and ending December 31, 1997, each such general hospital shall receive as an allocation 50 percent of the projected distribution to such general hospital pursuant to subdivision (d)(2) for 1996 and 50 percent of the amount determined in accordance with subdivisions (d)(2) and (h) of this section for rate periods commencing on and after January 1, 1997.

(ii) For the rate period commencing January 1, 1998 and ending December 31, 1998, each such general hospital shall receive as an allocation 25 percent of the projected distribution to such general hospital pursuant to subdivision (d)(2) for 1996 and 75 percent of the amount determined in accordance with subdivisions (d)(2) and (h) of this section for rate periods commencing on and after January 1, 1997.

(j) For rate periods commencing on and after January 1, 1997, distributions to the following categories of hospitals, general hospitals which qualified for distributions pursuant to section 86-1.84 of this Subpart for 1996, rural general hospitals that met the qualifications as a rural general hospital pursuant to clause (e) of section 86-1.52(a)(1)(iv) of this Subpart for 1996, and all other general hospitals, excluding major public general hospitals and general hospitals that qualified for distributions pursuant to section 86-1.66 of this Subpart, shall be adjusted as follows:

(1) For each category specified in this subdivision, 50 percent of the amount by which the allocation calculated pursuant to subdivisions (d)(2), (h) and (i) of this section for rate periods commencing on and after January 1, 1997 exceeds the projected distribution calculated pursuant to subdivision (d)(2) of this section for 1996 and, if applicable, section 86-1.84 of this Subpart for 1996 shall be reserved by the Commissioner for allocation to general hospitals within such category that would experience a loss based on each such general hospital's